A Guide To Your Benefits

BlueCross BlueShield of Delaware
A CareFirst Company

STATE OF DELAWARE
FIRST STATE PLAN

WELCOME!

This health care plan has been selected by the State Employee Benefits Committee of the State of Delaware. The plan benefits are administered by Blue Cross Blue Shield of Delaware (BCBSD).

This booklet explains your benefits. Please read this booklet carefully and keep it handy.

In this booklet, we sometimes abbreviate terms. For instance:

- **BCBSD** means Blue Cross Blue Shield of Delaware
- **SNF** means Skilled Nursing Facilities
- **DME** means Durable Medical Equipment

This booklet is not a contract. It explains your plan for easy reference. The benefits and terms and conditions of your plan are in an Account Contract on file with the State Personnel Office. The Account Contract is the final determination of the benefits and rules of your plan.

This booklet explains the benefits in effect as of July 1, 2005. It replaces all previous booklets.

HINTS TO GET THE MOST FROM YOUR BLUE CROSS BLUE SHIELD OF DELAWARE HEALTH CARE PLAN

- Always show your BCBSD ID card when you need care.
- Always follow Managed Care Guidelines.
- Read this booklet.
- Call BCBSD if you have any questions.

WHEN YOU HAVE QUESTIONS

Our Customer Service staff is ready to answer your questions. Here are reasons you may need to call us:

- asking about your plan
- reporting a lost or stolen ID card
- ordering a new ID card
- letting us know when you have a new address
- asking about a claim

You may call, write, email or visit with your questions.

To Reach Us By Phone

Local Calls: (302) 429-0260
Long Distance Calls: 1 (800) 633-2563

To talk to a Customer Service Representative, call 7:00 a.m. - 7:00 p.m., Monday through Friday. You can also get the following information when you call outside the Customer Service Representative hours:

7:00 a.m. - 11:00 p.m., Monday through Friday; 7:00 a.m. - 2:00 p.m. on Saturday

- Enrollment information
- Claims status
- Check on managed care approvals
- ID card requests

24 hours a day, 7 days a week

- Requests
- Help library

To Reach Us By Letter

Write to:

Customer Services
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

To Reach Us In Person

Visit our Walk-In Service Center at the Augustine Cut-off (the Accenture Building, formerly John Wanamaker) in Wilmington. Our address is:

Customer Services
1801 Augustine Cut-off
Wilmington, DE 19803

Signs outside of the building will direct you toward the correct entrance. Our visiting hours are 8:30 AM to 5:00 PM, Monday through Friday.

You may also visit us at several places in Kent and Sussex Counties. To find out the days, times and locations, call BCBSD's Customer Service Department.

To Reach Us On The Internet

Internet Address: www.bcbsde.com

To Reach the Referral Center (for Managed Care)

Referral Center
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: (302) 421-3333
Long Distance Calls: 1 (800) 572-2872

To Reach the Behavioral Health Care Department (for Mental Health and Substance Abuse Managed Care)

Behavioral Health Care Department
Blue Cross Blue Shield of Delaware
One Brandywine Gateway
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: (302) 421-2500
Long Distance Calls: 1 (800) 421-4577

TABLE OF CONTENTS

SCHEDULE OF BENEFITS – FIRST STATE PLAN

The next pages describe what's covered under your health plan. Please read through these pages to make sure you know what's covered. Knowing what's covered helps you get the most from your health plan.

Many services have limits, deductibles or coinsurance. Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the following pages. Please read the following pages.

All payments are based on the allowable charge. BCBSD determines the allowable charge.

Preexisting conditions are covered.

DEDUCTIBLES

■ Calendar Year Deductible	$400 per person $600 per person and child $800 per family
■ Calendar Year Coinsurance Expense Limit	$600 per person $900 per person and child $1,200 per family

SERVICE	BENEFIT
Preventive Care and Wellness Programs	
■ Well Baby Care	100% Covered, no deductible.
■ Routine Physical Exams	100% Covered, no deductible.
■ Routine Immunizations	100% Covered, no deductible.
■ Routine GYN Exams (one per year)	100% Covered, no deductible.
■ Preventive Lab Tests	
▪ In-Network	100% Covered, no deductible.
▪ Out-of-Network	50% Covered, after the deductible.
(Pap Smears, Hemoglobin Tests, Cholesterol Tests, Blood Sugar Tests, Urinalysis, Blood Occult, Prostate Specific Antigen Tests, Lead Poison Screening Tests)	
■ Routine Mammograms	
▪ In-Network	100% Covered, no deductible.
▪ Out-of-Network	65% Covered, after the deductible.
■ Colonoscopy	100% Covered, no deductible.
■ Flexible Sigmoidoscopy	100% Covered, no deductible.
■ Barium Enema	100% Covered, no deductible.
■ Diabetes Education	100% Covered, no deductible.
■ Early Maternity Discharge Program	100% Covered, no deductible.

SERVICE	BENEFIT
Hospital and Other Facility Benefits	
■ Inpatient Hospital Care	80% Covered, after the deductible, for unlimited days of care. (Exception: 90% Covered, after the deductible, if preadmission testing is done as outpatient and deductible and/or coinsurance expense limit are not met.)
■ Outpatient Surgical Facilities	80% Covered, after the deductible. (Exception: 90% Covered, after the deductible, if preadmission testing is done as outpatient and deductible and/or coinsurance expense limit are not met.)
■ Skilled Nursing Facilities	80% Covered, after the deductible; 120 day limit; benefits renew after 180 days without care.
Surgical-Medical Benefits	
■ Surgical and Anesthesia Benefits	80% Covered, after the deductible.
■ Inpatient Medical and Consultation Benefits	80% Covered, after the deductible.
■ In Vitro Fertilization	See benefit description; limited to $30,000 per employee's lifetime.
■ Artificial Insemination	See benefit description; limited to $600 per employee's lifetime.
■ Organ Transplants	See benefit description; limited to $1,000,000 lifetime maximum per type of covered transplant.
Maternity Benefits	
■ Prenatal and Postnatal Care	80% Covered, after the deductible.
■ Inpatient Hospital Care	80% Covered, after the deductible. (Exception: 90% Covered, after the deductible, if preadmission testing is done as outpatient and deductible and/or coinsurance expense limit are not met.)
■ Birthing Center	95% Covered, no deductible.
■ Obstetric and Newborn Care	80% Covered, after the deductible.
Emergency Services	
■ Emergency Ambulance	80% Covered, after the deductible.
■ Emergency Room	80% Covered, after the deductible.
■ Emergency Services (Doctor's Services at Emergency Room)	80% Covered, after the deductible.
Therapeutic & Diagnostic Services	
<u>Outpatient Services</u>	
■ Chemotherapy, Radiation and Respiratory Therapy, Dialysis	80% Covered, after the deductible.
■ Physical Therapy	80% Covered, after the deductible.
■ Speech Therapy	80% Covered, after the deductible.
■ Occupational Therapy	80% Covered, after the deductible.

SERVICE	BENEFIT
■ Cognitive Therapy	80% Covered after the deductible for up to 30 consecutive days, beginning on the first day of treatment
■ Cardiac Therapy	80% Covered after the deductible, for up to 3 sessions per week and 3 months of treatment
■ Lab Tests	
▪ In-Network	100% Covered, no deductible.
▪ Out-of-Network	50% Covered, after the deductible.
■ Imaging Services	
▪ In-Network	100% Covered, no deductible.
▪ Out-of-Network	65% Covered, after the deductible.
■ Machine Tests	100% Covered, no deductible.
■ Preadmission Testing	95% Covered, no deductible.
Inpatient Services	
■ Therapeutic Services	80% Covered, after the deductible.
■ Diagnostic Services	80% Covered, after the deductible.
Other Covered Services	
■ Hospice	95% Covered, no deductible, for up to 240 days.
■ Home Health Care	80% Covered, after the deductible, for up to 240 days.
■ Visiting Nurse Services	80% Covered, after the deductible.
■ Home Infusion Services	80% Covered, after the deductible.
■ Inpatient Private Duty Nursing Services	80% Covered, after the deductible. for up to 240 hours in a 12 month period.
■ Doctor's Visits	80% Covered, after the deductible.
■ Chiropractic Services	80% Covered, after the deductible.
■ Second Surgical Opinion	95% Covered, no deductible.
■ Durable Medical Equipment	80% Covered, after the deductible.

Mental Health and Substance Abuse Benefits
(Does not include authorized care for Serious Mental Illness)

Benefits are subject to a **separate** deductible, equal to the plan deductible. The 50% coinsurance you pay does not count towards your coinsurance expense limit.

■ Inpatient Mental Health, Partial Hospital Care, and Residential Care	50% Covered for up to 240 days per benefit period for all care combined; inpatient care is limited to 60 days per benefit period. Benefits renew after 90 days without care.
■ Outpatient Mental Health Care	50% Covered.
■ Substance Abuse Treatment – **Authorized Care**	80% Covered, after the deductible, for unlimited days of care.
■ Substance Abuse Treatment – **Unauthorized Care**	25% Covered for up to 30 inpatient days or 60 outpatient days per treatment period. Maximum of 2 270-day treatment periods per lifetime, each separated by 365 days. 1 inpatient day reduces outpatient days by 2 days. 2 outpatient days reduce inpatient days by 1 day.

DEDUCTIBLES AND COINSURANCE

In the *Schedule of Benefits*, we refer to deductibles and coinsurance. These amounts are your share of payment. These terms are described below.

If your spouse is eligible for and not enrolled in his/her own employer's plan

- **the 20% benefit will be calculated after the deductible has been met, and**
- **coinsurance amounts you pay will not be applied to your coinsurance expense limit**.

CALENDAR YEAR DEDUCTIBLE

Your benefits have a $400 calendar year deductible per person. You pay the first $400 for services.

You also have calendar year deductibles as follows:

- $600 per person and children
- $800 per family

This is how they work:

- one family member meets the individual deductible of $400, then
- any combined payments for the rest of your family members can be totaled to meet the balance.

When the family deductible is met, no more deductible is taken for all members for the rest of the year.

Note: You have separate deductibles for mental health and substance abuse care. These deductibles are equal to the plan deductible for other benefits.

CALENDAR YEAR COINSURANCE EXPENSE LIMIT

After the deductible is met, most benefits are paid at 80% of the allowable charge (some are paid at 95%). This means the difference of 20% (or 5%) is your coinsurance.

Your benefits have a $600 coinsurance expense limit per person. This applies when the coinsurance adds up to $600. Then, we pay 100% for the rest of the year. The 100% is based on the allowable charge.

You also have coinsurance expense limits as follows:

- $900 per person and children
- $1,200 per family

This is how they work:

- one family member meets the individual coinsurance expense limit of $600, then
- any combined payments for the rest of your family members can be totaled to meet the balance.

When the family coinsurance expense limit is met, we pay 100% for all members for the rest of the year. The 100% is based on the allowable charge.

The following are not included in your coinsurance expense limit:

- amounts you pay toward the deductible, or
- coinsurance you pay for mental health care (that is not for Serious Mental Illness), or
- coinsurance you pay for substance abuse care.

HOW THE DEDUCTIBLE AND COINSURANCE WORK

Example #1:

Suppose you have medical expenses of $50.00 in allowable charges. Here's how your deductible would be reduced:

Your deductible is.....$400
Less: Your medical expenses.....$50
Equals: The amount you still have to pay to meet your deductible:.....$350

Example #2:

When you meet your deductible, your benefits are paid at 80%. This means your coinsurance is 20% (100% - 80% = 20%). Suppose you've met your deductible, and have medical expenses of $500 in allowable charges. Here's how your coinsurance expense limit is reduced:

Your coinsurance expense limit is $600
Less: Your coinsurance times the medical expenses (20% X $500).....$100
Equals: The amount of coinsurance you still have to pay to meet
your coinsurance expense limit:.....$500

When you meet your coinsurance expense limit, benefits are paid at 100% for the rest of the calendar year.

CARRYOVER

You may **carryover** your deductible to the next calendar year. This means that deductible amounts you have in October, November and December can be applied to next year's deductible. You can do this if you didn't terminate your coverage and reenroll.

There is no carryover for the coinsurance expense limit.

THE MANAGED CARE PROGRAM

This section describes the Managed Care Program. The program is administered by the Referral Center. The Referral Center helps you and your doctors make sure that care you receive is appropriate.

Note: You do **not** need to follow managed care requirements if this plan is secondary (see the section, *Coordination of Benefits).*

Under the Managed Care guidelines you (or your doctor) must call BCBSD **before** you:

- go into a hospital or skilled nursing facility (SNF) for a non-emergency
- remain in the hospital or SNF beyond the date we first approved
- receive home health care

These guidelines are described in more detail below.

The Referral Center can be reached at:

Local Calls: (302) 421-3333
Long Distance Calls: 1-800-572-2872

There are also special guidelines for mental health and substance abuse care. These guidelines are described later in this booklet.

AUTHORIZATION FOR HOSPITAL ADMISSIONS

Before going into the hospital, you must have BCBSD's authorization. You or your doctor should call us at least two days before admission. This doesn't apply to maternity or emergency cases. BCBSD will review your case. From the review, BCBSD may:

- find that care can be best provided as an outpatient, or
- authorize the admission and the number of inpatient days, or
- not authorize the admission.

For emergency admissions, you or your doctor must call us within 48 hours of admission. The Referral Center reviews the admission. If approved, they assign the number of days needed.

If these guidelines are not followed, BCBSD will deny payment for the hospital charges.

AUTHORIZATIONS FOR OTHER SERVICES

These guidelines apply to:

- skilled nursing facility admissions
- home health care
- home infusion

You or the provider must call the Referral Center for authorization at least two days before you begin having care. The Referral Center reviews the request. If approved, they decide the number and type of services authorized.

If these guidelines are not followed, BCBSD will deny payment for all services.

AUTHORIZATIONS TO EXTEND YOUR CARE

Sometimes your hospital or Skilled Nursing Facility stay will need to be extended. You or your doctor must call for authorization before the last approved day or visit. The Referral Center reviews the request. If authorized, BCBSD will determine the additional days or visits.

If these guidelines are not followed, BCBSD will deny payment for the hospital charges for the additional days.

CASE MANAGEMENT

When you need certain care, BCBSD may choose to provide optional benefits not normally included under your plan. These optional benefits will replace or minimize the need for existing health care plan benefits. Such benefits may include modification to copayments, coinsurance, deductibles or covered services. We work with you and your doctor when considering optional benefits.

Optional benefits may include

- coordinating care when you leave the hospital
- providing care in your home
- providing educational materials

BCBSD offers case managed optional benefits only as long as the benefits are medically necessary, and the total benefits paid aren't more than the plan benefits. When we provide optional benefits for you, it doesn't mean we need to provide optional benefits for you or anyone else at any other time or in any other situation.

You may accept or reject the optional benefits. If you reject the optional benefits, you are still entitled to benefits under this plan.

PROVIDER RESPONSIBILITIES

Participating providers agree to follow BCBSD's Managed Care Guidelines. They **may not** bill you for amounts reduced, if:

- they didn't follow the guidelines.

They **may** bill you for amounts reduced, if:

- they did follow the guidelines, and
- the Referral Center denied services, and
- you choose to have them anyway.

Non-participating providers may not know about the guidelines. It's up to you to call the Referral Center. If the guidelines aren't followed, you may be billed 100% of the charges.

GENERAL CONDITIONS

- If you do not comply with the requirements, BCBSD will reduce or deny payment.
- We do not pay for services that are not covered, even when the Referral Center authorizes them, except for expanded case managed care.

- Penalties you pay are not credited toward any deductible or coinsurance requirement.
- You don't need to follow managed care requirements if this plan is secondary (see the section, *Coordination of Benefits).*

APPEALS

You may disagree with a decision the Referral Center makes. If so, you may file a written appeal with us. See the section, *Benefits Appeal,* for more information.

EVALUATING NEW TECHNOLOGY AND TREATMENT

BCBSD is committed to offer you quality benefits and services. We have established a clearly defined process to evaluate whether new health care technology and treatments are medically appropriate and supported by sound research.

OUR EVALUATION PROCESS

Our Medical Technology Assessment Committee meets quarterly to evaluate newly proposed technology and treatment benefits. The Committee is made up of:

- physicians
- nurses
- health care specialty providers
- senior-level quality administrators

The Committee consults comprehensive, nationally recognized research sources. These sources may include reports from the National Institute of Health, the Journal of the American Medical Association, the New England Journal of Medicine and others as needed.

The Committee uses the following evaluation criteria:

- The technology or treatment must have final approval from the appropriate regulatory body (such as the U.S. Food and Drug Administration).
- The scientific evidence must be conclusive.
- The technology or treatment must improve overall health outcomes. The health improvement must be available outside the investigational setting.
- The technology or treatment must be as good as other established treatment alternatives.
- The technology or treatment must be within the scope of local clinical practice and standards.

Through this process we help make sure that you receive quality health care benefits and services.

EMERGENCY AND URGENT CARE

EMERGENCY CARE

If you have a life threatening emergency, go directly to the nearest emergency provider. We cover the emergency facility, ancillary services and physician care when:

- the condition is serious enough to cause a prudent person to seek emergency care,
- a delay in care might cause permanent damage to your health, and
- you have care within 48 hours from the onset of the condition.

Some examples are:

- broken bones
- heavy bleeding
- sudden, severe chest pain
- poisoning
- choking
- convulsions
- loss of consciousness
- severe burns

COVERAGE FOR EMERGENCIES:

Emergency care is covered for life threatening emergencies only. The facility must be a hospital or a freestanding emergency facility operating with physicians and nursing personnel on a 24 hour, 7 days per week schedule. You may have a copayment for the emergency facility. The copayment is waived if you're admitted to the hospital directly from the emergency room.

Emergency care is not paid if you didn't have a life-threatening emergency.

URGENT CARE

Urgent care is for an injury or sudden illness that isn't life threatening, but you need care within a day or two to avoid a serious problem. For urgent care you can either

- see your regular doctor, or
- seek care at an urgent care center.

An urgent care center is a medical facility staffed by physicians and other medical personnel equipped to provide treatment of minor illnesses and injuries of an urgent nature which require prompt, but not emergency treatment.

HOW TO USE THE LAB AND IMAGING NETWORK

Your benefit plan includes a managed care network for lab and imaging services. The network includes facilities and providers who offer quality, cost-effective care. This type of program uses the terms *Network* and *Out-of-Network.*

NETWORK PROVIDERS

When you use a Network provider, you receive a higher level of coverage. When you use an Out-of-Network provider, you have to pay more.

You're not required to use the Network. But, if you take the extra step you can

- lower the amount you have to pay, and
- get higher benefit levels.

GETTING THE MOST OUT OF YOUR COVERAGE

If you need outpatient imaging or lab services, remind your doctor that you want to go to a Network provider. Your *Network Provider Directory* has a list of the network providers. You can also call BCBSD for provider information. BCBSD's numbers are:

Local Calls: 1-302-429-0260
Long Distance Calls: 1-800-633-2563

BENEFIT LEVELS

When you have lab testing and imaging done as an outpatient, your benefits are:

	Network Provider	Out-of-Network Provider
■ Imaging (such as an x-ray, mammogram, CAT scan, MRI)	100%	65%
■ Lab tests (such as a Pap smear test, or cholesterol test)	100%	50%

In most cases, the following applies when you use an Out-of-Network provider:

- your benefit is subject to the deductible described in the *Schedule of Benefits,* and
- coinsurance you pay is not applied to the coinsurance expense limit described in the *Schedule of Benefits.*

EXCEPTIONS

Exceptions to the above are

- services done by an out-of-state provider (benefits are paid like any other lab or imaging service)

- emergency care (benefits are paid at 80% subject to the deductible and coinsurance. See *Emergency Room* for more information)

- preadmission tests done by an Out-of-Network hospital that the hospital needs before admitting you (benefits are paid at 95%). However, services done by an Out-of-Network hospital that is **not** admitting you will be paid Out-of-Network.

- services done as part of a surgical procedure at an Out-of-Network hospital (benefits are paid at 80% subject to the deductible and coinsurance). However, services done before you have surgery in the doctor's office or ambulatory surgical center must be done at a Network provider to get the higher payment.

- diagnostic x-rays for oral surgery (benefits are paid at 80% subject to the deductible and coinsurance. See *Surgical Services* for more information about dental surgery)

- services that are part of the hospice program (benefits are paid at 95%)

- services that are part of home health care (benefits are paid at 80% subject to the deductible and coinsurance)

- services that are part of In Vitro Fertilization (benefits are paid at 80% subject to the deductible and coinsurance)

Note: Out-of-Network hospitals are hospitals with imaging and lab departments that are not Network providers.

PREVENTIVE CARE AND WELLNESS PROGRAMS

Check the *Schedule of Benefits* for limits and payments.
Follow managed care rules to get the highest benefit!

PREVENTIVE CARE

BCBSD promotes preventive care to help you stay well. We administer these benefits according to the BCBSD Preventive Health Guidelines materials. These materials contain details of when we pay for Preventive Care. All the terms and conditions of your benefit plan apply to the Preventive Health Guidelines materials.

Please note: BCBSD has the right to change these benefits at any time.

EXAMINATIONS

Benefits are provided for:

- well baby care
- routine physical exam
- routine GYN exam and Pap smear

TESTS AND SCREENINGS

Some examples of covered routine tests and screenings are:

- hemoglobin test
- cholesterol test
- blood sugar test
- blood antigen test for prostate cancer
- blood occult
- lead screening test
- mammogram
- flexible sigmoidoscopy

ROUTINE IMMUNIZATIONS

Some examples of covered routine immunizations are:

- Hepatitis A
- Hepatitis B
- Varicella (chickenpox) vaccine
- DTaP (diphtheria, pertussis, tetanus)
- Td (Tetanus)
- MMR (measles, mumps, rubella)
- IPV (polio)
- Hib (haemophilus influenza)
- Lyme vaccine
- Influenza
- Pneumococcal

Immunizations considered by BCBSD to be experimental in nature are not covered. Please refer to your Preventive Health Guidelines for all terms and conditions.

WELLNESS PROGRAMS

DIABETES EDUCATION

We provide coverage for a diabetes education program. You may have one course per calendar year. We won't pay benefits unless you finish the entire course.

The diabetes course has:

- 8 - 12 hours of group instruction
- for up to 8 weeks

You will receive information about:

- diet
- meal planning
- glucose monitoring
- insulin usage
- oral medication
- foot care

After you complete the course, you may have 2 more visits per calendar year. These visits will help you learn new skills to manage diabetes.

You need to call the BCBSD Customer Service Representative for names and locations of approved providers. The numbers are:

- Local calls: (302) 429-0260
- Long distance calls: 1-800-633-2563

EARLY MATERNITY DISCHARGE PROGRAM

The early maternity discharge program covers services after you have your baby. Services are provided if you are discharged from the hospital within

- 24 hours of a vaginal delivery, or
- 72 hours of a Cesarean section.

The services are:

- A visit by a registered nurse to your home. The visit is within 24-48 hours after you leave the hospital.
- Eight hours of homemaker services in your home, but only if you've had the visit from the registered nurse.

You have to call the visiting nurse service. If you don't call, then

- the nurse won't visit you, and
- you won't get the homemaker services.

HOSPITAL AND OTHER FACILITY BENEFITS

Check the *Schedule of Benefits* for limits and payments.
Follow managed care rules to get the highest benefit!

INPATIENT HOSPITAL CARE

Your care is covered for the following services when you're in the hospital. Please check the *Schedule of Benefits* for any day limits.

Inpatient hospital stays must be precertified prior to admission.

Room And Board

Room and board, special diets and general nursing care are covered. Payment is made at the semiprivate room rate. If you have a private room, you pay the extra charge above the semiprivate rate. We cover private rooms only when medically necessary. We also cover intensive care when medically necessary.

Other Hospital Care

When medically necessary, we cover:

- use of operating room and recovery room
- drugs listed in the U.S. Pharmacopoeia or National Formulary
- therapy:
  - chemotherapy by a doctor
  - occupational therapy as called for in your doctor's treatment plan when:
    - needed to help your condition in a reasonable and predictable time, or
    - needed for an effective maintenance program
  - physical therapy as called for in your doctor's treatment plan when:
    - done by a doctor or licensed physical therapist, and
    - needed to help your condition in a reasonable and predictable time, or
    - needed for an effective maintenance program
  - radiation therapy for cancer and neoplastic diseases
  - inhalation therapy by a doctor or registered inhalation therapist
  - speech therapy, when
    - done by a licensed or state certified speech therapist; and
    - ordered by a doctor; and
    - done to improve speech impairment caused by:
      - disease
      - trauma
      - congenital defect
  - cognitive therapy done by an approved provider. The diagnoses eligible for coverage are
    - stroke with cognitive impairment, or
    - head injury or trauma.
  - cardiac therapy
    - Services must begin within 4 months following certain serious conditions or procedures.
- surgical dressings

- administration of blood or blood plasma (but not blood itself)
- machine tests
- imaging exams (such as X-rays)
- durable medical equipment
- lab exams
- dialysis

MATERNITY CARE

Hospital and Birthing Center care is covered for:

- pregnancy
- childbirth
- miscarriage

There are no time limits for childbirth admissions. This plan complies with the Newborns' and Mother's Health Protection Act of 1996, which states that group health plans may not restrict mothers' and newborns' benefits for a childbirth admission to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Maternity admissions may be less than the 48 or 96 hours only if both you and your doctor agree.

See the section, *Early Maternity Discharge Program,* for information about more maternity benefits.

NEWBORN CARE

Infant nursery care is covered while the mother remains an inpatient for maternity. Sick infants in a hospital are covered for the first 31 days after the infant's birth: There is no coverage for the child after that 31 days unless:

- a parent has coverage that includes children, or has requested that enrollment change within the first 31-day period, and
- the baby is added to the coverage, and
- if applicable, pays any additional premium.

See the section entitled "A Guide to Enrollment", Changes in Enrollment (Newborns) for more information.

OUTPATIENT SURGICAL FACILITIES

You're covered for minor surgeries done as an outpatient. Surgeries may be done at:

- hospitals
- approved ambulatory surgical centers

Dental surgery is normally only covered when done in the dentist's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by BCBSD.

EMERGENCY ROOM

You're covered for emergency care in emergency facilities we've approved. See the *Emergency and Urgent Care* section for more information.

SKILLED NURSING FACILITIES (SNFs)

You're covered for up to 120 days per confinement in a SNF. We may review your stay every 14 days. A confinement includes all admissions not separated by 180 days. Benefits renew after 180 days without inpatient SNF care.

The plan covers:

- skilled nursing and related care as an inpatient
- rehabilitation when needed due to illness, disability or injury

The plan doesn't cover intermediate, rest and homelike care.

SURGICAL AND MEDICAL BENEFITS

Check the *Schedule of Benefits* for limits and payments.
Follow managed care rules to get the highest benefit!

SURGICAL BENEFITS

Surgical services include:

- cutting and operative procedures (including reconstructive surgery following a mastectomy)
- treatment of fractures and dislocations
- delivery of newborns

These services can be done:

- in hospitals
- in approved ambulatory surgical centers
- at home
- in the doctor's office

The allowable charge includes pre- and post- operative care done by surgeons. We don't pay separate charges for such care.

Dental Surgery

Dental surgery is only covered for:

- extracting bony impacted teeth; or
- correcting accidental injuries (to the jaws, cheeks, lips, tongue, roof and floor of mouth).

Such surgery is covered when done in a dentist's office. Dental surgery done in a hospital outpatient department or ambulatory surgical center must be approved by us.

Multiple Surgical Procedures

When one doctor does more than one procedure on a patient in a single day:

- we provide full contract benefits for the procedure with the highest allowable charge, and
- we determine coverage for the other procedures using special rules on multiple surgical procedures.

When a procedure normally done in one stage is done in two or more stages

- we cover the entire procedure as one stage.

Surgical Assistants

Surgical assistants are covered for inpatient surgery if

- BCBSD thinks it's medically necessary, and
- there is no residency program at the hospital where the surgery is done.

Benefits for an assistant surgeon are paid like any other surgeons.

ANESTHESIA

Anesthesiologist services are covered when medically necessary.

ORGAN TRANSPLANTS

The benefits described below apply to human organ transplants for:

- heart
- heart-lung
- lung
- liver
- pancreas

Coverage includes:

- **hospital, surgery and medical service**s (The same limits and rules apply as for other benefits.)
- **surgical, storage and travel costs for organ donation** (There's a $10,000 limit.)
- **travel to and from the transplant site** (This includes the recipient and one other person. If the recipient is a minor, the cost for two other people is covered. Reasonable lodging and meal costs are also covered. There's a $150 limit for lodging and meals per day. There's a $10,000 aggregate limit.)

Transplant benefits are applied during a benefit period. The benefit period runs from 5 days before to one year after the transplant.

There's a $1,000,000 lifetime limit for each type of covered transplant. This applies across all BCBSD plans. So, if you change from one plan to another, all payments are added to the limit. Also, all other benefit limits apply. This includes coinsurance, waiting periods, etc.

(Kidney, cornea, and bone marrow transplants are covered like other surgeries. They aren't covered when we consider them to be experimental.)

IN VITRO FERTILIZATION (IVF)

The following procedures are covered when done as an outpatient:

- In vitro fertilization (IVF)
- gamete intrafallopian transfer (GIFT)
- zygote intrafallopian transfer (ZIFT)

The following limits apply:

- dependent children aren't covered for any of the above procedures
- women must be at least age 18 and must not have reached their 45th birthday
- there is a proven infertility problem
- infertility isn't due to a voluntary sterilization
- other infertility methods must have been tried (this includes artificial insemination)
- a pretreatment plan must be approved by BCBSD.

There's a $30,000 lifetime payment limit. Charges are paid at the same benefit level as outpatient surgery. The $30,000 limit applies even when you switch to another BCBSD plan or to another plan offered by the State of Delaware. If pregnancy results, your maternity benefits are then applied.

Services included in the $30,000 maximum are:

- office visits
- surgical services

- hospital outpatient services
- anesthesia
- lab exams
- prescription drugs

Donor services are not covered.

ARTIFICIAL INSEMINATION (AI)

Artificial insemination (AI) procedures are covered when done as an outpatient. The following limits apply:

- dependent children aren't covered for AI procedures
- there's a proven infertility problem
- infertility isn't due to voluntary sterilization
- donor services aren't paid

There's a $600 lifetime payment limit. Charges are paid at the same benefit level as other outpatient surgery care. The $600 limit includes only approved AI procedures. The $600 limit applies even when you switch to another BCBSD plan. If pregnancy results, your maternity benefits are then applied.

INPATIENT MEDICAL SERVICES

Medical visits by the attending doctor are covered when you're an inpatient. This does not include when you're having surgery. Surgeon pre- and post-operative care is covered under global surgery payment.

We normally cover one doctor visit per day. Usually this is your attending doctor. If another specialist visits you, we may cover the visit. Visits must be medically necessary.

See the *Mental Health and Substance Abuse Care* section for a description of related doctor visits.

INPATIENT CONSULTATION SERVICES

Inpatient consultation services are covered when:

- the doctor in charge certifies in writing it's medically necessary, and
- the specialist isn't the attending doctor or operating surgeon, and
- the specialist is a doctor.

Only one consultation per specialty per admission is covered.

EMERGENCY CARE

You're covered for emergency care in emergency facilities we've approved. See the *Emergency and Urgent Care* section for more information.

OBSTETRIC CARE

Obstetric care by doctors and midwives is covered. Coverage is the same as for other surgical and medical care. This includes:

- prenatal care
- anesthesia
- delivery
- postnatal care

Midwives are licensed and certified nurses. They must be practicing within the scope of their license. When we cover midwife care, we do not cover a doctor's care for the same services.

See the section, *Early Maternity Discharge Program,* for more information about your maternity benefits.

NEWBORN CARE

Infant nursery care is covered while the mother remains an inpatient for maternity. Sick infants in a hospital are covered for the first 31 days after the infant's birth: There is no coverage for the child after that 31 days unless:

- a parent has coverage that includes children, or has requested that enrollment change within ther first 31-day period, and
- the baby is added to the coverage, and
- if applicable, pays any additional premium.

See the section entitled "A Guide to Enrollment", Changes in Enrollment (Newborns) for more information.

THERAPEUTIC AND DIAGNOSTIC SERVICES

Check the *Schedule of Benefits* for limits and payments.
Follow managed care rules to get the highest benefit!

INPATIENT THERAPEUTIC AND DIAGNOSTIC CARE

When you're an inpatient, professional care for therapeutic and diagnostic care is covered. See the *Inpatient Hospital Care* section for more information.

OUTPATIENT THERAPEUTIC AND DIAGNOSTIC CARE

The therapeutic and diagnostic benefits described below apply when you're an outpatient in:

- a provider's office
- an approved lab
- a hospital's outpatient department

THERAPY SERVICES

Covered care includes:

- chemotherapy by a doctor
- occupational therapy as called for in your doctor's treatment plan. Only the facility charge is covered. Therapy must be:
  - needed to help your condition in a reasonable and predictable time, or
  - needed for an effective maintenance program.
- physical therapy as called for in your doctor's treatment plan. Therapy must be:
  - done by a doctor or licensed physical therapist, and
  - needed to help your condition in a reasonable and predictable time, or
  - needed for an effective maintenance program.
- radiation therapy for cancer and neoplastic diseases
- inhalation therapy by a doctor or registered inhalation therapist
- speech therapy. Therapy must be:
  - done by a licensed or state certified speech therapist
  - ordered by a doctor
  - needed to improve speech problems caused by disease, trauma, congenital defect, or recent surgery
- dialysis
- cognitive therapy done by an approved provider. The diagnoses eligible for coverage are
  - stroke with cognitive impairment, or
  - head injury or trauma.
- cardiac therapy
  - Services must begin within 4 months following certain serious conditions or procedures.

DIAGNOSTIC SERVICES

Covered care includes:

- imaging services
- lab tests
- machine tests

Don't forget to use Network labs and imaging providers to get the highest benefit!

PREADMISSION TESTING

We cover tests done before a scheduled admission for surgery.

Tests must be done

- as an outpatient, and
- within 7 days before the admission

Tests are not covered if

- they are done for diagnosis
- they are repeated after you enter the hospital
- you cancel or postpone the admission

However, if the hospital or physician cancels or postpones the admission, the testing will be covered.

Don't forget to use a Network provider for lab and imaging services!

OTHER COVERED SERVICES

Check the *Schedule of Benefits* for limits and payments.
Follow managed care rules to get the highest benefit!

HOSPICE

Hospice provides palliative and support care to terminally ill patients and their families. Hospice is covered up to 240 consecutive days from the first day of care. BCBSD must authorize the hospice care.

You may have hospice care at home, in an inpatient hospice facility or a nursing home.

What Is Covered Under Hospice:

- care by a hospice doctor
- nursing care
- home health aide supervised by a registered nurse
- social service guidance
- nutritional counseling and meal planning
- physical therapy
- speech therapy
- occupational therapy
- spiritual counseling by the hospice
- medical supplies that are needed to manage the illness
- infusion therapy for pain management
- bereavement counseling for the family for up to 13 months following the death of the patient

Some services you have during hospice care are not paid under this benefit. They are paid like other covered benefits, such as

- care by a non-hospice doctor
- prescription drugs
- durable medical equipment (DME)
- imaging and lab tests
- inhalation therapy

What's Not Covered Under Hospice:

- private duty nursing
- care not prescribed in the approved treatment plan
- chemotherapy or radiation therapy (except when needed to manage the illness)
- financial, legal or estate planning
- hospice care in an acute care facility

HOME HEALTH CARE

Home health care services are covered. Care is for up to 240 consecutive days from the first day of service. Benefits renew after 90 days without home health care. Home health care is covered when it is

- on a part-time, visiting basis
- in place of or after you have inpatient hospital care
- through an approved coordinated home care program

- prescribed by the attending physician

The plan covers:

- visiting nurse services
- dietary advice
- social service guidance
- physical therapy
- lab tests
- drugs
- dressings
- medical supplies
- services which are directed by your doctor.

Home health care for nervous and mental disorders is not covered.

HOME INFUSION

Home infusion is home care for receiving needed infusion medicine. It involves the use of an infusion pump with fluids, nutrients and drugs. BCBSD must approve the treatment plan. The plan must be prescribed by a doctor in lieu of inpatient care.

What Is Covered Under Home Infusion:

- nursing care
- medications (includes drug preparation and monitoring)
- solutions
- needed infusion pumps, poles and supplies

What's Not Covered Under Home Infusion:

- delivery costs
- record keeping costs
- doctor management
- other services which do not involve direct patient contact
- drugs normally covered under a drug program (whether or not BCBSD provides your drug coverage)

INPATIENT PRIVATE DUTY NURSING

Private duty nursing care is covered up to 240 hours in a year. We may review the case in advance. We may review the case again after 80 hours of care. You must be an inpatient in an acute hospital. Care must be:

- ordered by the attending doctor
- for the same condition you're hospitalized for
- medically necessary
- approved by the hospital

This care isn't covered when done in special care units of the hospital, such as:

- self-care units
- selective care units
- intensive care units

This care isn't covered when done as a convenience even if authorized by your doctor.

EMERGENCY AMBULANCE AND PARAMEDIC SERVICES

Emergency ambulance and paramedic services are covered when:

- a sudden, serious condition requires travel right away, and
- you are taken to the nearest hospital that can treat you.

When you can travel by private car, the ambulance isn't covered. Only one-way travel to the hospital is covered. Air ambulance is covered only when no other means of travel is appropriate.

When billed separately, these items are not paid:

- patient care equipment
- reusable devices
- first aid supplies

Benefits are not provided when paramedic services are given by state, county or local government.

DOCTOR'S VISITS

Visits with your doctor in the office or your home are covered. This includes visits for:

- injury or illness
- allergy treatment
- visits to a specialist

Routine foot care is not covered. However, foot care needed because of diabetes is covered.

Note: Don't forget to use a Network provider if your doctor prescribes any testing (such as a blood test or throat culture). You must use a Network provider to get the highest benefit!

VOLUNTARY SECOND SURGICAL OPINION

You have coverage for a second surgical opinion (SSO). The second surgical opinion confirms that you need elective surgery. Coverage for an SSO includes:

- office visits to a doctor who didn't recommend the surgery in the first place
- tests related to your condition

Elective surgery is surgery that

- is covered under this plan, and
- is not an emergency

You decide whether or not you want a second surgical opinion. You don't have to follow the SSO doctor's suggestions in order to have coverage. If the first opinion and the second opinion don't agree, then we cover a third opinion. We'll also cover related tests for the third opinion.

Reminder: To get the highest benefit, use Network providers when you have tests.

CHIROPRACTIC CARE

The following care is covered when done by a licensed chiropractor:

- office visit for initial evaluation

- manual manipulation of the spine
- hot or cold packs, ultrasound, traction therapy and electrotherapy

The following limits apply:

- three modalities per visit
- one visit per day
- treatment must:
  - help your condition in a reasonable and predictable time, or
  - be needed for an effective maintenance program.

Chiropractic X-rays are covered only for X-rays of the spine. They are covered under your Outpatient Imaging benefit. You must use a Network imaging provider to get the highest benefit. Your benefit is reduced if you get an x-ray by your chiropractor.

Covered durable medical equipment (DME) is covered. This includes cervical collars and lumbar sacral supports. These are covered under your DME benefit.

Machine tests are covered. They are covered under your Machine Testing benefit.

Reminder: To get the highest benefit, use Network providers when you have tests.

DURABLE MEDICAL EQUIPMENT

Covered durable medical equipment (DME) includes items which are:

- prescribed by a doctor, and
- useful to a person only during an illness or injury, and
- deemed by BCBSD to be medically necessary and appropriate.

Some examples of DME are:

- prosthetic devices
- orthopedic braces
- wheel chairs
- hospital beds

We also pay to replace or repair prosthetic devices.

We may pay for rent or purchase. If we rent the equipment, our total payment won't exceed the purchase price.

DME Not Covered:

- items for comfort or convenience
- dental prosthetics
- orthotics
- diabetic supplies covered as a pharmacy benefit through Express Scripts/Value Rx.

EYEWEAR DISCOUNTS

Your BCBSD coverage includes an eyewear discount program. You and your family can save money on eyewear by going to one of the program's participating providers. To get a list of participating providers and the products subject to discount, call 1-800-424-1155.

To get more information about this program, please contact your Agency Benefits Representative or call BCBSD Customer Service at 302-429-0260 or 1-800-633-2563.

Please note: BCBSD has the right to change or discontinue this program at any time.

MENTAL HEALTH AND SUBSTANCE ABUSE MANAGED CARE

Your plan has Mental Health and Substance Abuse Managed Care Guidelines. The guidelines help assure the care you receive is appropriate. Follow these guidelines to avoid benefit reductions.

WHAT YOU MUST DO

When you need mental health or substance abuse care, follow these steps:

- **Call the Behavioral Health Care Department.** The Behavioral Health Care Department is staffed by trained professionals. They review your needs and approve your care. If you can't call yourself, your provider or a friend may call us. Make sure we're called before having care. You may reach the Behavioral Health Care Department at:

  Local Calls: (302) 421-2500
  Long Distance Calls: 1-800-421-4577

- **Use the approved panel provider.** The Behavioral Health Care Department refers you to a panel provider. You must use the panel provider.

- **Follow the approved treatment plan.** The Behavioral Health Care Department works with your provider to set up a treatment plan. Follow the treatment plan to get coverage.

IF YOU ARE ALREADY RECEIVING CARE

If you were receiving care before this health care plan began, let us know right away. The Behavioral Health Care Department will work out a transition treatment plan. You must notify us within 30 days after this health care plan begins.

IN AN EMERGENCY

If you need emergency care and are unable to contact us, seek care right away. You must call us within 24 hours of receiving emergency care. If you can't call yourself, your provider or a friend may call us.

HOW BENEFITS MAY BE REDUCED

If you don't follow the guidelines, payment is reduced to the "Unauthorized Care" level. This means you'll be responsible for the rest of the charges.

If your care is not medically necessary, benefits will be denied.

PROVIDER RESPONSIBILITIES

All mental health and substance abuse panel providers agree to follow these guidelines. They may not bill you for amounts reduced or denied if they didn't follow the guidelines.

Non-panel providers may not know about the guidelines. If you see a non-panel provider, you may be billed the full charge.

CALCULATION OF BENEFIT REDUCTIONS

If you do not meet the requirements, your payment is reduced. Here is how the payment due will be calculated:

From the allowable charge:

- First, we will subtract the deductible amount, if any, then
- Second, we will subtract the managed care program reduction, then
- Third, we will apply any calendar year and lifetime maximums, and then
- Finally, we will reduce payment due to coordination of benefits if necessary.

The balance then left, if any, will be the amount we pay. If the penalty is denial of payment, we pay nothing.

APPEALS

You may disagree with a decision the Case Manager makes. If so, you may file a written appeal with us. See the section, *Benefits Appeal,* for more information.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Refer to the *Schedule of Benefits* for limits and payments.
Also, refer to Managed Care Guidelines.

SERIOUS MENTAL ILLNESS

"Serious Mental Illness" means any mental health disorder which is in one of the following categories:

- schizophrenia
- bipolar disorder
- obsessive-compulsive disorder
- major depressive disorder
- panic disorder
- anorexia nervosa
- bulimia nervosa
- schizo affective disorder
- delusional disorder

HOW MENTAL HEALTH BENEFITS ARE PAID

Payment of mental health benefits depends upon whether you have care for

- Serious Mental Illness, or
- other mental health disorders

Benefits for Serious Mental Illness

When managed care requirements are met, benefits for a Serious Mental Illness are paid at the same level as any other illness. For example, inpatient hospital benefits for a Serious Mental Illness are the same as inpatient hospital benefits for having a surgical procedure.

Benefits for Other Mental Health Disorders

You are covered for other mental health disorders. You must follow managed care guidelines or your benefits will be reduced. Your benefits are also subject to a separate deductible and coinsurance expense. The *Schedule of Benefits* shows how benefits are paid when you have care for other mental health disorders.

MENTAL HEALTH CARE

The *Schedule of Benefits* shows the day limits for each benefit period. A benefit period

- is 240 service days which
  - begins on the first day you have treatment
  - ends when you are discharged or reach the end of 240 days
- includes all combined days you have care in a
  - hospital (you have up to 60 days per benefit period)
  - partial hospital program
  - residential program
- renews after 90 days without care

INPATIENT CARE

You're covered for inpatient mental health care for approved diagnoses. This benefit covers doctor and facility costs. Electroconvulsive therapy by a doctor is also covered.

PARTIAL HOSPITAL CARE AND RESIDENTIAL PROGRAMS

Partial Hospital Care and Residential Programs are for patients who:

- are not confined to a facility, and
- need intensive care not available as an outpatient.

Partial Hospital Care is provided for 8 or fewer hours per day.

OUTPATIENT CARE

Outpatient care covers:

- brief crisis intervention psychotherapy
- psychiatric consultations
- supportive psychotherapeutic treatment
- psychological tests (limit of 8 hours of tests per year)

Outpatient care includes:

- attention deficit disorder (ADD), and
- attention deficit hyperactivity disorder (ADHD)

Care must be by a panel provider such as a

- doctor, or
- licensed clinical psychologist, or
- licensed clinical social worker.

Care must be done in the provider's office or as a hospital outpatient. Such care must first be reviewed by a doctor.

What's Not Covered

- aptitude tests
- conditions that aren't emotional or personality disorders
- care past the time needed to determine mental deficiency or retardation
- mental disorders not likely to improve

SUBSTANCE ABUSE CARE

Care is covered for treatment of alcoholism and drug addiction. Care is covered as an inpatient or outpatient. The program and the facility must be approved by BCBSD.

AUTHORIZED CARE

Authorized Inpatient and Intensive Outpatient Substance Abuse Care is provided at the same level as care for other medical conditions. Both the program and the facility must be approved by BCBSD.

UNAUTHORIZED CARE

Unauthorized Substance Abuse Care is subject to the limits described below and on the *Schedule of Benefits.*

You have coverage for up to

- 30 inpatient days, or
- 60 outpatient days.

This is called your **Service Day Maximum.** Inpatient and Outpatient day limits are combined as follows:

- Each inpatient day used reduces your available outpatient days by two days.
- Two days of outpatient care reduce your available inpatient days by one day.

The *Schedule of Benefits* may use the phrase **Treatment Period.** A **Treatment Period** ends the earlier of:

- 270 days from the first day you had substance abuse care; or
- the day you reach your **Service Day Maximum.**

Treatment periods must be separated by 365 days without care. There's a limit of 2 treatment periods per lifetime.

WHAT IS NOT COVERED

The following services and items are not covered.

- Injury or illness on the job. This includes any care normally covered under Workers' Compensation or occupational disease laws.
- Care given by institutions or agencies owned or operated by the government, unless the law requires otherwise. This includes the Veteran's Administration.
- Care needed through an act of war. This applies if the war occurred after this plan became effective.
- Care needed through service in the armed forces of any country.
- Care as a result of any criminal act in which you conspired or took part. One example is BCBSD does not pay for the court mandated instruction course or rehabilitation program resulting from driving under the influence of alcohol or drugs.
- Care given by a family member. This includes parents, children, spouses or siblings.
- Care given by any person living with you.
- Care you can have without charge in the absence of insurance.
- Rest cures, custodial care or homelike care. This applies even if prescribed by a doctor.
- Exams or tests done as inpatient for convenience. This applies when such care could be done as outpatient.
- Dental care, except certain dental care noted in the *Medical and Surgical Benefits* section.
- Eyeglasses, contact lenses and all procedures for refractive correction.
- Hearing aids.
- Eye or hearing exams, unless noted elsewhere in this booklet.
- Treatment of Temporomandibular Joint (TMJ) Dysfunction Syndrome. This includes exams, fittings, nutrition counseling and occlusal adjustment. However, you do have coverage for the treatment of TMJ Dysfunction caused by:
  - Documented organic joint disease, or
  - Joint damage as a result of physical trauma.

  Benefits for a TMJ appliance prescribed for an approved diagnosis are limited to $350.
- Routine foot care.
- Orthotic equipment and devices, such as:
  - foot inserts
  - arch supports
  - lifts
  - corrective shoes
- Blood, blood components and donor service.

- Care for cosmetic reasons. This includes routine care of acne and hair loss.

- Care not directly related to diagnosis or treatment of illness or injury. Care must:
  - be consistent with the symptom or treatment of the condition
  - meet the standard of accepted professional practice
  - not be solely for anyone's convenience
  - be the most appropriate supply or level of care safely provided. For inpatient care, it means care cannot be safely provided as an outpatient.

- Routine exams, unless noted elsewhere in this booklet. Excluded are exams for:
  - potential employers
  - insurers
  - schools
  - camps
  - marriage physicals
  - any other third party

- Computerized gait analysis or electrodynographic tests.

- Care for vision therapy or orthoptics.

- Immunizations or inoculations that are not considered routine childhood immunizations and/or immunizations that are not listed in the 2002 Preventive Health Guidelines. Immunizations or inoculations for travel are not covered.

- Care for weight loss, even if advised by a doctor. The only exception is gastric stapling or gastric bypass which we will cover only if:
  - you are over 100 lbs. overweight, and
  - you have hypertension or other weight related medical problems, and
  - BCBSD authorizes it.

- Care given by your employer's health department.

- Care we consider to be experimental or investigational. This includes care we consider not to be accepted medical practice. This also includes care that requires government agency approval, and the approval hasn't been granted.

- Prescription drugs, even if your doctor writes you a prescription. Prescriptions are covered through the prescription vendor contracted with the State of Delaware.

- We cover one service per day by a professional provider. If more than one service is done, we cover only the service with the greater allowable charge.

- Care by:
  - a school infirmary
  - a student health center
  - staff working at the above

- Drugs or care received in violation of law.

- Speech therapy for:
  - attention disorders
  - behavior problems
  - conceptual handicaps
  - learning disabilities
  - developmental delays
- Occupational or physical therapy for developmental delay.
- Change of sex surgery, except to correct congenital defect.
- Surgery to reverse voluntary sterilization.
- Thermography.
- Acupuncture.
- Massage Therapy
- Nutritional Counseling.
- Convenience items, including:
  - phones
  - TVs
  - radios
  - other personal items

A GUIDE TO CLAIMS

Claims must be filed within 2 years from the time you receive care. Claims filed beyond 2 years will not be paid.

HOW TO FILE CLAIMS

In most cases, claims are filed for you by your provider. This is usually true when you use a **participating provider.**

Always be sure to show your BCBSD ID card when you receive care!

WHEN YOU USE A PARTICIPATING PROVIDER

A provider participating with BCBSD files claims for you. The provider also accepts BCBSD's allowable charge as full payment for covered services. You still pay your share (any copayment or coinsurance). BCBSD pays participating providers for your care.

WHEN YOU USE A NONPARTICIPATING PROVIDER

Some providers don't participate with BCBSD. These providers may ask you to pay full cost for your care.

You may need to submit a claim for your care. We'll pay the allowable charge to you, less any copayment or coinsurance. This is the same payment we make to participating providers.

You must pay any balance over our payment.

WHEN YOU'RE OUT OF AREA

When you receive care in another state, show your BCBSD ID card. Providers participating with the local plan may file your claim with the local plan.

If the local plan is in the BlueCard® Program:

- the local plan accepts the provider's claim
- payment is made to the provider
- you pay any copayment or coinsurance.

If the local plan isn't in the BlueCard Program:

- you must file the claim with BCBSD

IF YOU NEED TO FILE A CLAIM

To file a claim, you'll need a claim form. To obtain a form, call Customer Service. Let us know how many forms you need. We'll send your forms right away. Please follow the instructions on the form. Attach an itemized receipt from the provider. Send your claim to this address:

Claims
Blue Cross Blue Shield of Delaware
P. O. Box 8831
Wilmington, DE 19899-8831

BENEFITS APPEAL

If you disagree with our claim decision, call or write the Customer Service Department within 180 days of BCBSD's original decision. Explain why you believe that the claim was not paid correctly and provide any additional information that you believe we should consider in reviewing your case.

BCBSD will review the appeal and respond to you promptly.

If you have an emergency medical condition or a life-threatening illness, you may request an **expedited appeal**. We will make a decision and notify you and your physician within 72 hours of your request.

Call or write BCBSD at:

Customer Service
Blue Cross Blue Shield of Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

Local Calls: (302) 429-0260
Long Distance: (800) 633-2563

A BCBSD Appeal Form is available on our website. Our Internet address is: **bcbsde.com**

COORDINATION OF BENEFITS

BCBSD coordinates payments with any other plan that covers you. We assure the combined payments don't exceed 100% of the Allowable Expense. This process is described below.

We will pay 20% for your spouse's benefits if

- your spouse's employer has a benefit plan, and
- your spouse is eligible, and
- your spouse didn't join the plan.

TERMS

These terms are used to explain the rules for Coordination of Benefits (COB):

- *Allowable Expense* is a necessary, reasonable and usual health care expense. The expense must be covered at least in part by a plan that covers you.
- *COB Provision* sets the order in which plans pay when you're covered by two or more plans.
- *Other Plan* is any arrangement you have that covers your health care.
- *Primary Plan* is the plan applied before any other plan. Benefits under this plan are set without considering the other plan's benefits.
- *Secondary Plan* is the plan applied after the other plan. Benefits under this plan may be cut because of the other plan's benefits.

ORDER OF BENEFITS DETERMINATION

The primary and secondary plan payments are set by these rules:

- A plan with no COB rules is primary over a plan with such rules.
- A plan which covers you as an employee is primary over a plan which covers you as a dependent.
- A plan which covers you as an active employee is primary over a plan which covers you as a non-active employee. Non-active means a laid off or retired employee. This rule also applies if you're the employee's dependent.
- For a child covered by plans under both parents, these rules apply:
  - The plan of the parent whose birthday comes first in the year is primary.
  - If both parents have the same birthday, the plan that covered one parent longer is primary.
  - The other plan's COB rules may set the payment order by the parent's gender. In this case, the male parent's plan is primary.
- If the parents are divorced or separated, this order applies:
  - First, the plan of the parent with custody;
  - Then, the plan of the spouse of the parent with custody; and
  - Last, the plan of the parent not having custody.

This order can change by court decree. A court decree may make one parent responsible for the child's health care costs. If so, that parent's plan is primary.

- If these rules don't decide the primary plan, then the plan covering you longest is primary.
- There may be two or more secondary plans. If so, these rules repeat until this plan's obligation for benefits is set.

HOW COB WORKS WITH MANAGED CARE

The rules below will apply to you, your spouse and your dependent children.

COB When This Plan is Primary

The State's managed care rules must be followed. If you don't, benefits are coordinated by applying the penalties of this plan.

COB When This Plan is Secondary

BCBSD will never pay more than what we would pay if this plan were primary.

You don't have to follow the State's managed care rules when this plan is secondary. However, you should follow the primary plan's managed care rules.

- If you do, both plans will pay up to the maximum.
- If you don't, we'll apply the other plan's penalties when calculating your benefit payment.

You will have to follow the primary plan's In-Network or Out-of-Network managed care guidelines to get the maximum payment.

Exceptions are:

- This plan may cover care that the other plan doesn't cover. If this happens, we'll pay benefits as if this plan were primary. You must follow the State's managed care rules to receive maximum payment.
- The other plan may have a day or dollar maximum on a particular benefit. This plan will pay benefits if:
  - you've met the maximum for that benefit, and
  - this plan covers the particular benefit.

The State's plan will pay until you are again eligible for that benefit under the other plan.

To file a secondary claim, you'll need to send BCBSD a completed claim form (see *A Guide to Claims*, above) and a copy of your Notice of Benefits from the other carrier. That way we'll be able to see what the primary plan paid and what the managed care penalties were, if any.

HOW COB WORKS WITH THE PPO NETWORK

If you are covered under both a State plan and another plan, we will coordinate benefits.

When This Plan is Primary

If this plan is primary, the State's network and managed care requirements will apply.

When This Plan is Secondary

If the primary (other) plan has managed care requirements or a preferred provider network, you must follow those guidelines to get maximum payment for both the primary and secondary (State) programs. If you followed the other plan's managed care requirements, you don't have to follow the State's managed care requirements.

We will apply the other plan's out-of-network payment reductions when applicable.

Exceptions are:

- If the primary plan doesn't cover the services and the secondary (State) plan does, the secondary plan becomes primary for the particular services. Benefits will then be paid according to the State's network and managed care guidelines.

- If you've met the primary plan's benefit maximum and the benefit is covered under the secondary (State) plan, the secondary plan becomes primary for the particular service. Benefits will then be paid according to the State's network and managed care guidelines (until you can again get coverage under the other plan for the particular benefit).

You'll need to send BCBSD a copy of your Notice of Benefits from the other carrier. That way we'll be able to see what the primary plan paid and what the network penalties were, if any.

EFFECT ON BENEFITS

- When this plan is primary, we pay without regard to any secondary plan.

- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.

- If the other plan is primary and reduces or does not cover benefits because there is coverage under this plan, then we'll calculate the benefit as if
  - the State's plan is secondary, and
  - the other plan had paid the normal payment.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We have the right to decide when to apply COB rules. To do this, we may obtain information as needed. We may also release information to any organization or person as needed.

You must give us the information we need to apply COB rules. This includes information about you and your dependents. If you do not cooperate, we may deny payment.

FACILITY OF PAYMENT

If we're primary, but the other plan paid a claim, we have the right to pay the other plan. Our payment will be the amount we decide is our share under COB rules. Such a payment will meet our obligation under this plan.

RIGHT OF RECOVERY

If we paid more than our share under COB rules, we'll recover the excess from:

- you or any person to or for whom such payments were made
- any insurance plan
- other organizations

A GUIDE TO ENROLLMENT INFORMATION

WHO IS COVERED

WHO CAN BE COVERED

Your plan may cover:

- You
- Your legal spouse
- Your unmarried children

NOTE: BCBSD may need proof of dependency, disability and support. Your right to benefits depends on your providing BCBSD with this proof.

TYPES OF ENROLLMENT

You may enroll in one of these coverage types:

- **Self** for you only
- **Self and Child(ren)** for you and your children
- **Self and Spouse** for you and your spouse
- **Family** for you, your spouse and your children

YOU ARE ELIGIBLE TO BE COVERED IF:

- you are a regular officer or employee of the State;
- you are a regular officer or employee of a State agency or school district;
- you are a pensioner already receiving a State pension;
- you are a pensioner eligible to receive a State pension;
- you are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years;
- you are regularly scheduled full-time employee of any Delaware authority or commission participating in the State's Group Health Insurance program;
- you are a regularly scheduled full-time employee of the Delaware Stadium Corporation or the Delaware Riverfront Corporation;
- you are a paid employee of any volunteer fire company participating in the State's Group Health Insurance program;
- you are a regularly scheduled full-time employee of any county, soil and water conservation district or municipality participating in the Group Health Insurance program;
- you are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/Firefighter Pension Plan with Chapter 88 of Title 11 or the county and municipal pension plan under Chapter 55A of Title 29.
- you are a pensioner eligible to receive a State pension.

CHILDREN

To be covered, a child must be

- unmarried, and
- under age 21, and
- either
  - born to you or your spouse,
  - adopted by you or your spouse,

- placed in your home for adoption, or
- living in your home in a parent/child relationship. However, if the child's parent also lives in your home, the child is not eligible for coverage.

BCBSD may require proof of dependency.

FULL-TIME STUDENTS

Full-time Students can be covered up to age 24. You must submit A *Student Certification Form* each year to receive coverage. We must receive the form before August 1. You may get the form from us.

The child must take a minimum of 12 credit hours every semester. However, only 9 credit hours are necessary if the student is in the semester before graduation. A student nurse must be enrolled in a degree program.

The school must have

- a regular faculty, and
- a set curriculum, and
- a regular student body attending.

The school may be a

- prep school, or
- junior college, or
- seminary, or
- university

DISABLED CHILDREN

Disabled children can be covered after age 21 (or age 24 for students). They may be covered if:

- they were covered by BCBSD before reaching age 21 (or age 24 for students), and
- they are not married, and
- they cannot support themselves because of a disability, and
- their disability happened before age 21 (or age 24 for students), and
- they depend on you for support.

You must file a *Disabled Child Application* form with BCBSD. You may get the form from us.

SPOUSE'S BENEFITS

This is how we pay benefits for spouses enrolled under this plan:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after you spouse's plan pays if your spouse
  - is eligible for, and
  - **is** enrolled in his/her employer's plan.

- We pay 20% of allowable covered charges if your spouse
  - is eligible for, and
  - **is not** enrolled in his/her employer's plan.

The combined payments can't be more than 100% of covered charges. For more details, see the section, *Coordination of Benefits*.

The above will not apply if your spouse is not enrolled in his/her employer's plan because your spouse

- doesn't work full-time, or
- isn't eligible because he/she doesn't work enough hours to be eligible, or
- isn't eligible because he/she hasn't completed a waiting period, or
- has to pay more than half of the plan's cost (including flexible spending account dollars), or
- doesn't have health coverage at work.

ENROLLMENT

ENROLLMENT DATE

Your enrollment date is the later of

- your date of hire for Timely Enrollees (if you're in an employee class eligible for health coverage), or
- the date you move to an employee class that is eligible for health coverage (such as going from part-time to full-time employee), or
- the date coverage begins if you're a Special Enrollee or a Late Enrollee.

HOW TO ENROLL

You may enroll yourself and your dependents when you are first eligible or at open enrollment by completing an enrollment form/application and returning it to your Human Resources Office (with any premium owed). If you want to cover your spouse, you'll need to complete the *Spousal Coordination of Benefits Form*. You can get both the enrollment form/application and the Spousal COB from your Agency Benefits Representative.

HOW TO DECLINE COVERAGE

You may decline coverage if you don't want to enroll when you're first eligible. You will need to complete an enrollment form/application indicating you are waiving coverage and return it to your Agency Benefits Representative.

WHEN COVERAGE BEGINS

When your coverage begins is determined by

- when you are eligible for coverage, and
- when you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a

- Timely Enrollee, or
- Special Enrollee, or
- Late Enrollee

TIMELY ENROLLEES

Who Can be a Timely Enrollee

You are a Timely Enrollee if you enroll within 30 days of when the employee is first eligible to be covered.

When Coverage Begins

Coverage for new employees (and their dependents) begins

- on the first of the month following the employee's hire date, or
- on the first of the month following the date of enrollment when an employee moves to a class that is eligible for health coverage.

SPECIAL ENROLLEES

Who Can Be A Special Enrollee

You are a Special Enrollee if you request enrollment within the 30-day enrollment period. The enrollment period is within 30 days of

- losing other health coverage under certain conditions, or
- obtaining a new dependent because of marriage, birth (enrollment period is 31 days, see section below entitled *Changes in Enrollment, Newborns*), adoption or placement in the home for adoption, or court ordered support.

Employees or dependents may qualify as Special Enrollees if the following requirements are met:

- *Employees*: if you're not already enrolled in this plan, you must
  - be eligible to enroll in this plan, and
  - enroll at the same time you enroll a dependent.

- *Spouses and Children*: you're a dependent of an employee
  - who is already enrolled or is eligible to enroll in this plan, and
  - who enrolls at the same time you enroll.

If you don't request enrollment within the 30-day enrollment period, you are a Late Enrollee.

Loss Of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the employee or dependent) must meet all these conditions:

- you were covered under another group or individual health plan when coverage was previously offered under this plan (when first eligible or during open enrollment), and

- when this plan was previously offered, you declined coverage under this plan because you had other coverage, and

- the other coverage was either:
  - COBRA continuation coverage that is exhausted, or
  - other (non-COBRA) coverage that was lost because
    - you are no longer eligible, or
    - the employer stopped contributing, and
    - you request enrollment within 30 days of the date
      - COBRA continuation coverage is exhausted, or
      - the other (non-COBRA) coverage was lost because
        - you lost eligibility, or
        - the employer stopped contributing, and

- you can prove the loss of the other coverage by providing proof of coverage, such as a *Certificate of Coverage*.

New Dependents

You (employee or dependent) are a Special Enrollee if the employee gets a new dependent because of

- marriage, or
- birth, or
- adoption, or
- placement of a child in the home for adoption, or
- court ordered support.

When Coverage Begins

Coverage for Special Enrollees begins as follows. If the Agency Benefits Representative was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted, coverage begins for:

- *Employees*: the first day of the month after the loss of coverage
- *Spouses*: either the date of marriage or the first day of the month after the marriage
- *Children*: either
  - the date of birth, adoption or placement in the home for adoption; or
  - the first day of the month after you request enrollment if
    - you lost coverage under a prior plan, or
    - your parent got married.

Remember, if you request enrollment after the 30-day enrollment period, you (and your dependents) will be Late Enrollees!

LATE ENROLLEES

Who Can Be A Late Enrollee

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at an open enrollment period.

Children are Late Enrollees if enrollment was not requested within 30 days of

- birth,
- adoption, or
- placement in the home for adoption.

When Coverage Begins

Coverage for Late Enrollees begins the first day of the new plan year.

CHANGES IN ENROLLMENT

You can change your enrollment because of one of the reasons described below.

MARRIAGE

You may add your spouse when you get married. You must request enrollment within 30 days after the marriage; a copy of your marriage certificate is required by your State of Delaware Agency Benefits Representative. If added premium is due, you must pay when you request enrollment. If you request enrollment within the 30-day period, your spouse will be a Special Enrollee. If you don't request enrollment within the 30-day period, your spouse will be a Late Enrollee.

Don't forget, when you get married you'll also need to complete the *Spousal Coordination of Benefits Form*.

NEWBORNS

You may add your newborn child. A birth certificate or legal documentation needs to be supplied to your State of Delaware Agency Benefit Representative. Hospital nursery care is covered for infants when the mother is having hospital obstetrical care. If a sick infant must stay in the hospital, the baby remains covered for the first 31 days after the infant's birth. There is no coverage after that 31 days unless:

- You have coverage that already covers dependent children. You still must request enrollment within 31 days of the child's birth.
- You have coverage that doesn't cover dependent children and you request enrollment for coverage that includes children. You must request enrollment for the child within 31 days of the child's birth. If added premium is due, you must pay it when you enroll.

If you request enrollment within the 31-day period, the newborn will be a Special Enrollee. If you don't request enrollment within the 31-day period, the child will be a Late Enrollee.

ADOPTED CHILDREN

You may add a child because of adoption or placement in your home for adoption. A birth certificate or legal documentation needs to be supplied to your State of Delaware Agency Benefit Representative. You must request enrollment within 30 days of the date of adoption or placement in the home in order for the child to be a Special Enrollee. If you don't request enrollment within the 30-day period, the child will be a Late Enrollee.

OTHER CHILDREN

You may add a child other than a newborn or adopted child, such as a step-child. A birth certificate or legal documentation needs to be supplied to your State of Delaware Agency Benefit Representative. You must request enrollment within 30 days of the date the child became eligible in order to be a Special Enrollee. If you don't request enrollment within the 30-day period, the child will be a Late Enrollee.

WHEN CONTINUATION OF COVERAGE UNDER COBRA ENDS

You may have declined coverage under this plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee.

When your COBRA continuation coverage is exhausted, you may request enrollment in this plan within 30 days. If you request enrollment within the 30-day period, you will be a Special Enrollee. If you don't request enrollment within the 30-day period, you will be a Late Enrollee.

MEDICARE ELIGIBILITY

At age 65 you become eligible for Medicare. Medicare is provided by the Federal Government. It is not part of this health care plan.

If you are an active employee working at age 65, you have a choice of benefit plans:

- you can continue coverage in this plan until you retire. This plan will be primary.
- you can be covered under Medicare. Medicare will be primary. You won't have any other coverage through the State. You can buy Medicare Supplemental coverage directly from BCBSD.

About 3 months before you reach age 65, contact

- your Human Resources Office, and
- Social Security Administration Office

Follow the same guidelines when your spouse reaches age 65.

You have to be an active, full-time employee

- to be covered under this plan when you reach age 65.
- for your spouse to be covered under this plan when he or she reaches age 65.

Please note: If your option is Medicare Supplemental coverage with BCBSD, you must be enrolled in and retain both Parts A and B of Medicare to be eligible for coverage.

HIPAA CERTIFICATE OF CREDITABLE COVERAGE

A federal law called HIPAA requires that the State of Delaware Group Health Plan (the "Plan") provide a Certificate of Creditable Coverage (a "Certificate") to each individual who requests one so long as it is requested while the individual is covered under the Plan or within 24 months after the individual's coverage under the Plan ends. A certificate will also be automatically issued upon the termination of any individuals covered under the Plan, whether or not a request is made. The request can also be made by someone else on behalf of an individual. For example, an individual who previously was covered under this Plan may authorize a new health plan in which the individual enrolls to request a Certificate from this Plan. An individual is entitled to receive a Certificate upon request even if the Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to your organization's Human Resources Office.

All requests must include:

- The name of the individual for whom the Certificate is requested;

- Where a certificate is requested for a dependent individual, the name of the participant who is enrolled in the Plan; and
- A telephone number to reach the individual for whom the Certificate is requested or the participant who enrolled the individual, in the event of any difficulties or questions.
- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

After receiving a request that meets these requirements, your organization's Human Resources Office will send a request to the State of Delaware COBRA/HIPAA Administrator to provide the Certificate as soon as administratively feasible.

WHEN COVERAGE ENDS

The State of Delaware COBRA Administrator will provide you and your dependents with a standard *Certificate of Coverage* when you lose coverage under this plan. Also, you have up to 24 months following the loss of coverage to request a certificate. The *Certificate of Coverage* will show how long you were covered under this plan.

Please read the section, *Continuing your Coverage Under COBRA,* to see how you may extend your coverage.

Except in cases of divorce or a change in a child's status (see sections below regarding each), coverage ends the last day of the month in which you lose eligibility because of one of the events below.

DIVORCE

Former spouses are not eligible for coverage under this program. You must notify your Agency Benefits Representative of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. State "divorce" as the reason for the change.

Coverage ends on the date of the divorce.

LEAVE YOUR JOB

Coverage terminates at the end of the month in which you leave your job.

DEATH

Coverage ends for your dependents at the end of the month in which you die, except for dependents of pensioners. Coverage for dependents of pensioners ends either:

- the last day of the month of your death, or
- if contributions have already been made, the last day of the following month, or
- when the dependent no longer meets eligibility conditions.

CHANGE IN YOUR JOB STATUS

Coverage ends when you're no longer eligible through your job. This might happen if you begin to work fewer hours, etc. Please refer to the section, *You Are Eligible To Be Covered If*, above.

CHANGE IN CHILD'S STATUS

Your child's coverage ends the earlier of:

- December 31 of the year the child reaches age 21
- when the child marries
- end of the month when the child is no longer a full-time student (such as when he or she graduates)
- the end of the month in which a full-time student reaches age 24

THE PLAN IS CANCELED

Coverage ends the day your employer's contract with BCBSD ends.

BENEFITS AFTER YOUR COVERAGE ENDS

All benefits end when you lose coverage, except:

- if your employer cancels the plan, and
- if you are an inpatient on the date the plan ends.

You're covered for the care you receive as an inpatient. The plan covers you through the earlier of:

- 10 days after the plan ends
- until you are discharged

CONTINUING YOUR COVERAGE UNDER COBRA

You may continue your coverage after you lose coverage under this plan. This right is provided under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA). If you decide to continue your coverage, you will have to pay up to 102% of the cost of coverage.

The following is a brief explanation of the law:

EMPLOYEE

You (and your dependents) can continue coverage for up to 18 months if you lose group coverage because

- your hours at work are reduced, or
- your job ends (for reasons other than gross misconduct).

You, the employee, can continue coverage beyond 18 months if you:

- are disabled when you become eligible for COBRA coverage, or
- become disabled within the first 60 days of COBRA coverage, and
- are considered disabled under Social Security.

You are then entitled to an additional 11 months (totaling 29 months). Your cost would be 150% of the plan cost for months 19 through 29.

SPOUSE OF EMPLOYEE

Your spouse can continue coverage for up to 36 months if coverage ends because

- you die, or
- you divorce or legally separate from your spouse, or
- you become eligible for Medicare.

DEPENDENT CHILD OF EMPLOYEE

A child can continue coverage for up to 36 months if coverage ends because

- you die, or
- you and your spouse are divorced or legally separated, or
- you become eligible for Medicare, or
- the child is no longer considered a dependent under this plan.

NOTIFYING THE STATE

You need to let your Agency Benefits Representative know within 30 days of

- a divorce, or
- a child losing dependent status, or
- disability determination by Social Security.

Notify your Agency Benefits Representative within 30 days if Social Security determines you are no longer disabled.

After you notify your Agency Benefits Representative or the State of Delaware's COBRA Administrator, you will be sent information about COBRA and how much it costs. You can choose to continue coverage under COBRA. If you do, then you have the right to the same coverage as the active employees. If you don't, your coverage under this plan ends.

You should contact State of Delaware's COBRA Administrator if you have any questions. The phone number is: 1-800-877-7994.

WHEN YOUR COVERAGE UNDER COBRA ENDS

You can lose the coverage you continued under COBRA if:

- your employer no longer has any group health coverage, or
- you don't pay the premium on time, or
- you become eligible for Medicare, or
- you get coverage under another group plan. An exception may apply if the other plan
  - has a preexisting condition waiting period, and
  - provides credit for prior creditable coverage to offset the preexisting condition waiting period.

In such cases, you can be covered under both plans.

You are eligible to receive a standard *Certificate of Coverage* after you lose coverage under COBRA.

DIRECT BILLED PLAN

If your group plan ends, you may apply to BCBSD for a Direct Billed Plan. With a Direct Billed Plan, BCBSD bills you directly for your coverage. BCBSD offers three types of Direct Billed plans:

- Medically Underwritten
- Conversion
- Portability

You may apply for one of the three Direct Billed plans if:

- you left your employer
- you become divorced from a covered employee
- you lost coverage because you began to work fewer hours
- you were covered under your spouse, and your spouse died
- you no longer meet the dependent child or student requirements on age, marriage status, or financial support
- you chose COBRA continuation coverage, but the coverage time limit is exhausted

The Direct Billed Plan may have different benefits from your group plan. It may cover fewer items and pay a lower amount. Direct Billed Plans cover dependent children through December 31 of the year they reach age 19. Some Direct Billed Plans cover full time students beyond age 19. Dependents over age 19 can apply for a Direct Billed Plan of their own.

MORE ABOUT YOUR DIRECT BILLED PLAN OPTIONS

Medically Underwritten and Conversion Plans

The following information applies to the Medically Underwritten and Conversion Plans:

- You must apply within 30 days after your group plan ends.

- You cannot be eligible for any other group plan. This applies if you're eligible through your or your spouse's employer or any organization. It applies even if:
  - the other plan has a preexisting condition limit, or
  - the other plan denied your application.

- You cannot be eligible for Medicare.

- The applicant must
  - *Medically Underwritten*: satisfy medical underwriting.
  - *Conversion*: There is no medical underwriting.

There is a 12-month preexisting condition waiting period for the employee and his or her covered dependents. However, you can get credit for prior coverage under a Blue Cross Blue Shield plan if there is no lapse period between coverages.

Portability Plans

The following information applies to the Portability Plans:

- You, the applicant, must have 18 months of prior "creditable coverage."

- You must enroll no later than 63 days after the group plan ends.

- You are not eligible if you were most recently covered by a Direct Billed plan or other non-group coverage.
- You cannot be eligible for coverage under Medicare, Medicaid or another group plan.
- You do not have other health insurance coverage.
- Your most recent health insurance coverage was not canceled for your nonpayment of premium or fraud.
- You must have elected and exhausted COBRA continuation coverage available under the group plan.
- Your coverage is not retroactive. The earliest effective date would be the day after you post or deliver your application to BCBSD.

There will be no preexisting condition waiting period for the applicant if you apply within 63 days after your group coverage ends. Eligible family members who have prior coverage under a Blue Cross Blue Shield plan will get credit towards a 12-month preexisting condition waiting period if there's no lapse period between coverages.

For more information about Direct Billed Plans, call BCBSD's Customer Service department at the number listed in the front of your booklet.

GENERAL CONDITIONS

RELEASING NEEDED RECORDS

Your providers have information about you we need to apply benefits. When you applied for coverage, you agreed to let providers give us information we need. This includes the diagnosis and history of your care. This applies to any condition or symptom you had or for which you sought care. It may also include other information. We'll keep these records private as allowed by law.

When you applied for coverage, you authorized us to share records of your health when needed. We'll only share your records to apply your benefits. We may share your records with:

- a medical review board
- a utilization review board or company
- any other health benefit plan
- any other insurance company

If the records relate to fraud or other illegal act, we may disclose them to legal authorities. We may also use them in legal actions.

We may charge a fee for making copies of claim records.

DUAL ENROLLMENT

You may have two or more benefit plans with us. If so, we'll coordinate benefits.

TIME LIMITS

Claims must be filed within 2 years after you receive care. We won't pay claims filed past the 2 year limit.

DENIAL OF LIABILITY

We're not responsible for the quality of care you receive from a provider. Your coverage doesn't give you any claim, right or cause of action against us based on care by a provider.

NON-ASSIGNABILITY

Any right you have to care is personal and cannot be assigned. Any right you have to payments is personal. Your payment rights cannot be assigned without our written approval.

SUBROGATION

Subrogation applies when:

- you have a right of recovery against a party (a person or organization), and
- your right of recovery is based on a legal claim, and
- the legal action involves a medical cost we paid.

When this happens, we're **subrogated** to your rights of recovery from that party. This applies whether or not you assert your claim. This means we're entitled to receive payment from that party.

You're required to assist us. This includes filling out and giving us any needed documents we request. You cannot settle or compromise your claim for medical costs without our written consent. We may cancel your coverage if you don't comply.

LEGAL ACTION

There's a 3 year time limit past which you cannot bring legal action against us for not paying a claim. The period begins on the date of service.

MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACT

We may cancel your coverage if we learn:

- Statements you made were untrue or not complete. This applies to when you applied and after you applied.
- You received or tried to receive benefits under this plan through misrepresentation, fraud or other intentional misconduct.
- You helped someone else in either of the acts as noted above.

ALLOWABLE CHARGE CALCULATIONS UNDER THE BLUECARD PROGRAM

There are times when you may receive care outside BCBSD's service area. Your claims will be paid through the BlueCard Program. The amount you pay is usually calculated as the lower of:

- the actual charges that are billed for your care, or
- the "price" that the other Blue Cross Blue Shield plan charges us

This "price" may be

- a simple discount, or
- an **estimated** final price (which may include settlements or other non-claim transactions with your provider), or
- a discount from billed charges (which may include **average** expected savings)

The **estimated** or **average** price may be changed in the future to correct past prices that were too high or too low.

Some states have laws that require the local Blue Cross Blue Shield plan to calculate your payment a certain way. Their methods may not show all the savings on a particular claim. When you have care in one of these states, your payment will be based on that state's method.

HOW BCBSD PROTECTS YOUR CONFIDENTIAL INFORMATION

It is necessary for BCBSD to receive information about you and your health to properly administer your plan benefits. This information is called "Personal Identifiable Health Information" and includes items such as your

- provider's name,
- tests that were done,
- diagnosis, or
- costs of treatment.

The following explains how BCBSD protects the confidentiality of your Personal Identifiable Health Information.

YOUR RIGHT TO CONSENT OR DENY RELEASE OF INFORMATION

By enrolling with BCBSD, you agree that we can receive information from your providers about care that you received. You also permit BCBSD to release your Personal Identifiable Health Information to business associates outside BCBSD, such as

- organizations that process claims,
- people who help coordinate services, or
- auditors.

We may need to release your Personal Identifiable Health Information to:

- process and pay claims,
- coordinate benefits when you're covered under another health plan,
- monitor care,
- help manage a chronic illness, such as diabetes or congestive heart failure,
- measure satisfaction through customer surveys, or
- conduct studies to measure our performance and our providers' performance.

In situations other than our routine business practice, BCBSD will only release Personal Identifiable Health Information if you sign the *Notice of Specific Consent* form. The form will contain information such as what is being released, who is getting the information and why the information is needed.

WITHDRAWING CONSENT

If you signed a *Notice of Specific Consent* form, you may withdraw that consent by calling or writing BCBSD's Customer Service Department. When you call, please specify which information indicated on the *Notice of Specific Consent* form you don't want released. However, if you withdraw that consent, the withdrawal will not affect any Personal Identifiable Health Information that BCBSD has already released based on your signing the *Notice of Specific Consent* form.

SHARING YOUR INFORMATION WITH YOUR EMPLOYER

At times it may be necessary for BCBSD to provide your employer with information such as

- medical cost experience
- claims volume
- cost savings.

This information helps your employer and BCBSD to determine future premium rates. This information is also used to monitor BCBSD's performance.

We do not release your Personal Identifiable Health Information to your employer without your signing a *Notice of Specific Consent* form, unless we are required to do so by law. The consent form will contain information such as what is being released, who is getting the information and why the information is needed.

YOUR RIGHT TO ACCESS MEDICAL RECORDS

You have the right to access the medical records which were originated by BCBSD. Some examples of such records are the *Notice of Benefits* and authorization of service forms. You can request your records by either writing or calling BCBSD's Customer Service Department.

HOW BCBSD PROTECTS YOUR PRIVACY

All BCBSD Employees are required to sign confidentiality statements when they're hired. Employees are then trained to follow certain guidelines to protect your confidential information. However, employees need to discuss your information with other employees when performing routine business practices, such as when they

- process claims,
- resolve disputes,
- answer inquiries, or
- coordinate care or benefits.

Much of your Personal Identifiable Health Information is on our computer network. Our employees are granted access to the network only on a need-to-know basis. BCBSD's management determines the level of access that employees need to perform their job. Our systems are password protected. Passwords are periodically changed to prevent unauthorized access.

BCBSD also requires that your providers follow confidentiality policies. We periodically audit providers to ensure that your medical records are kept private and that their staff has received confidentiality training.

USE OF MEASUREMENT DATA

We conduct surveys and health studies to measure customer satisfaction to help us improve our services. Health studies help us measure our performance and our providers' performance. Information collected during these studies is reported for the entire group rather than for one person. Your Personal Identifiable Health Information is not identified.

BCBSD sometimes uses outside agencies to conduct surveys and studies. BCBSD requires these agencies to sign a confidentiality agreement and to train their employees about confidentiality.

COMPLAINTS AND QUESTIONS

You have the right to file a complaint with us at anytime you feel that we have not maintained your privacy. You also have the right to ask questions about our confidential policy. To do either, please call BCBSD's Customer Service Department at:

Local Calls: 429-0260
Long Distance Calls: 1-800-633-2563

SUGGESTIONS AND COMPLAINTS

BCBSD welcomes questions, suggestions, and complaints. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about BCBSD's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

So that we can learn about our panel providers, you may also call or write us when you have a concern about:

- access to your PCP or other provider
- the care you received

BCBSD's Address

Customer Service
Blue Cross Blue Shield of Delaware
P.O. Box 8799
Wilmington, DE 19899-8799

BCBSD's Customer Service Telephone Numbers

Local Calls: 429-0260
Long Distance Calls: (800) 633-2563

BCBSD's Internet Address:

www.bcbsde.com

To learn how to appeal benefits, see "Benefits Appeal" in the section, *A Guide to Claims.*

DEFINITIONS

Account Contract: The agreement between the State and BCBSD which, for eligible employees and their dependents, provides for

- the provision of health care services and benefits, and
- administration of the health program.

Admission: The time you're an inpatient in a

- hospital
- skilled nursing home
- other facility

The admission runs from the day you're admitted until discharge.

Allowable Charge: The price BCBSD determines is reasonable for care or supplies. See "Allowable Charge Calculations Under the BlueCard Program" in *General Conditions* for more information.

Ambulatory Surgical Centers: Approved outpatient facilities for surgeries.

Birthing Center: Maternity centers that monitor normal pregnancies and perform deliveries.

BCBSD: Blue Cross Blue Shield of Delaware.

Coinsurance: The percent of allowable charges you pay.

Coinsurance Expense Limit: The total amount of coinsurance you pay. When you reach the Limit, our payments increase to 100% of allowable charges. The Limit does not include:

- the copayment
- amounts over the allowable charge
- charges for non-covered care

Confinement: For skilled nursing facilities, a confinement is one admission. It's also successive admissions if you're readmitted within 180 days. A new confinement begins when you're readmitted after 180 days after discharge.

Consultation: An interview or exam by a doctor other than the doctor treating you. The doctor is usually a specialist.

Copayment: The amount you pay at the time of service.

Deductible: The amount you pay before benefits are applied.

Doctor or Physician: A licensed physician, osteopath, podiatrist, chiropractor, or dentist. Such a provider must be acting within the scope of his or her license. (Coverage for dental care is limited. See *Surgical Care* description.)

Facility: A hospital, skilled nursing home, outpatient care site or like institution.

Hospital:

- *Acute Hospital:* An institution or division of an institution. On an inpatient basis, it primarily provides diagnostic and therapeutic facilities for:

  - surgical and medical diagnosis and treatment
  - care of obstetric cases

  Acute hospitals must be approved by:

  - the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
  - the American Osteopathic Association (AOA)

  Such hospitals charge for their care and receive payments from patients. Facilities and care are supervised or rendered by a staff of licensed doctors. Such hospitals provide 24 hour a day nursing care. The nursing care is under the supervision of registered graduate nurses.

- *Non-Acute Hospital:* An institution that provides care distinct from care usually received in an Acute Hospital. It may be a division, section or part of an Acute Hospital. Non-Acute Hospitals must be approved by:

  - BCBSD
  - the appropriate state or local agency (if required by law)

  Such hospitals charge for their care and receive payments from patients.

- The term **Hospital** does not include the following:

  - nursing homes
  - rest homes
  - health resorts
  - homes for aged
  - infirmaries or places solely for domiciliary care, custodial care, care of drug addition or alcoholism
  - similar facilities that provide mostly nonmedical services

Imaging: A diagnostic process that shows soft tissue and bones. This includes X-rays, mammograms and magnetic resonance imaging (MRI).

Inpatient: A person in a hospital or skilled nursing home for an overnight stay.

Machine Test: A test to diagnose a condition, using a device. This includes EKGs and EEGs.

Medically Necessary: Care, required to identify or treat a condition, which is:

- consistent with the symptoms or treatment of the condition
- meets the standards of accepted practice
- not solely for anyone's convenience
- the most appropriate supply or level of care which can be safely provided. For inpatient care, it means the care cannot be safely provided as an outpatient.

Outpatient: A person receiving care while not an inpatient in a hospital or other facility.

Participating Provider: A provider with a BCBSD participating contract. Participating providers will not bill you over the allowable charge for a covered service.

Prescription Drugs: Drugs which are:

- obtained only through a doctor's prescription
- listed in the U.S. Pharmacopoeia or National Formulary
- approved by the Food & Drug Administration

Provider: The organization or person giving care, supplies or drugs.

Reopening Period: The time when you may make changes to your coverage.

Semiprivate Room: A room with at least two beds.

Specialist: A doctor to whom you are referred for care. Sometimes called a *Referral Doctor*.

Specialized Care Facility: A facility for drug and alcohol treatment.

State: State of Delaware.

We, Us or Our: Refers to Blue Cross Blue Shield of Delaware.

You and Your: Refers to the employee or any of the employee's eligible dependents enrolled in this plan.